

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026272

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6913

STATE FILE NUMBER

FILED JUL 12 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN ST. LOUIS, MISSOURI

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION BARNES HOSPITAL

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Stoddard

c. CITY OR TOWN Dexter Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) West Bane, St. Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

First Middle Last
IVA MAE PHELAN

4. DATE OF DEATH Month Day Year
JUNE 30 1963

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☐ Divorced ☒

8. DATE OF BIRTH

10/11/1910

9. AGE (last birthday)

52

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

11. BIRTHPLACE (City and state or country)

At Home

12. CITIZEN OF WHAT COUNTRY

Memphis, Tenn. U.S.A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Josephine Higgins

14. NAME OF HUSBAND OR WIFE

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)
No Nil

16. SOCIAL SECURITY NO.

[Redacted]

17. INFORMANT

Carolyn Jones, Dumas, Arkansas.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Gastrointestinal hemorrhage

INTERVAL BETWEEN ONSET AND DEATH
48 hrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Lesion in distal ileum, etiology unknown

Years

DUE TO (c)

578x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/7/50 to June 30, 1963 and last saw her alive on June 30, 1963
Death occurred at 2:50 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

[Signature]

(Degree or title)

M.D.

22b. ADDRESS

BARNES HOSPITAL

22c. DATE SIGNED

7/1/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

7-2-63

23c. NAME OF CEMETERY OR CREMATORY

Bloomfield Cemetery

23d. LOCATION (City, town, or county) (State)

Bloomfield, Missouri.

24. FUNERAL DIRECTOR

ADDRESS

Watkins Funeral Home, Dexter, Mo.

25. DATE REC'D. BY LOCAL REG.

JUL 2 1963

26. REGISTRAR'S SIGNATURE

[Signature]

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Stanley H. Dixon

Licensed Embalmer No. 44193

P. O. Address H. R.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.